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The purpose of this study is to identify medical-ethical areas of concern faced in the hospitals of the greater San Antonio area. A modified Delphi technique was employed. First and second round questionnaires were sent to 136 chief executive officers, medical directors, chief financial officers, chief social workers, and administrators at hospitals that are members of the Greater San Antonio Hospital Council. Results indicated that the most important clinical and organizational ethics domains are (a) Patient Safety and (b) Patient Care. Within these domains, the most important ethical concerns involve (a) the reporting of medication errors and (b) documentation, respectively. *Other key concerns within the clinical domains were issues related to rights and responsibilities of staff.* Among the organizational domains, the most important concerns involved compliance, marketing, and billing issues.

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Study of Medical Ethics Areas of Concern in the Greater San Antonio Area

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Abstract

The purpose of this study is to identify medical-ethical areas of concern faced in the hospitals of the greater San Antonio area. A modified Delphi technique was employed. First and second round questionnaires were sent to 136 chief executive officers, medical directors, chief financial officers, chief social workers, and administrators at hospitals that are members of the Greater San Antonio Hospital Council. Results indicated that the most important clinical and organizational ethics domains are (a) Patient Safety and (b) Patient Care. Within these domains, the most important ethical concerns involve (a) the reporting of medication errors and (b) documentation, respectively. Other key concerns within the clinical domains were issues related to rights and responsibilities of staff. Among the organizational domains, the most important concerns involved compliance, marketing, and billing issues.

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Introduction

The healthcare industry faces unique challenges that are rooted in belief systems and values. For instance, healthcare decisions often involve individuals other than patients and providers. Nurses, social workers, case managers, and members of the clergy are often involved in healthcare decision-making; and in our litigious society, attorneys, judges, and various forensic experts may be involved as well In addition, despite the fact that the health and well being of the citizenry is central to our strength as a society, we treat healthcare like a common marketplace good in the United States. Because of such competing interests, the ethical issues that arise in the healthcare setting are numerous and often complex.

Further complicating ethical decision-making, medical staffs are often uncomfortable making decisions that involve ethical issues (Penticuff & Walden, 2000). Organizations often do not provide the much-needed education required to raise staff confidence levels in making ethical decisions. A survey published in the Australian Journal of Advanced Nursing (Johnstone, Da Costa, & Turale 2004) reported that only 8.3 percent of nurses who responded to the survey felt their organization provided enough training and resources to deal with ethical issues. Similarly, in the United States, discussion and training surrounding ethical decision-making often rests solely in the hands of those assigned to the hospital ethics committee (Ross, 1986). Until focused education and discussion occurs regularly throughout the organization, ethical decision-making will continue to be a neglected topic.

Literature Review

Ethics

Ethical educational programs that do exist typically revolve around the history of medical ethics, particularly in the areas of research, clinical ethics, and to a lesser extent organizational

ethics. Clinical ethics topics range from informed consent and the right-to-die to stem cell research. Organizational ethics issues commonly cited include rationing, which is a result of limited resources; discriminating policies; proper use of financial assets; and managed care practices. University-level medical ethics courses, although more prevalent today, were not necessarily available to the majority of the current workforce when they received their degrees. Ulrich, Soeken, and Miller (2003) found that 50 percent of their sample population had no ethics courses while enrolled in advanced practitioner programs. Further, 58 percent reported not receiving any medical ethics instruction throughout their professional preparation studies. Similarly, a 1998 study conducted by Redman and Fry, reported that 21 percent of respondents had no ethics education in their basic nursing programs. Since their basic program studies, 53 percent had not had any formal instruction in ethics and 38 percent had no continuing education related to medical ethics.

In addition to not providing training to equip staff for ethical decision-making, organizations have processes and hierarchies that create barriers. Penticuff and Walden (2000) reported that nurses are constrained by "organizational factors, such as institutional policies, administrative support for nurses' involvement in decisions, and institutional resources on nurses' ethical decisions." They found that because of organizational constraints nurses were often unwilling to take action to resolve ethical dilemmas and also unwilling to communicate concerns outside their own units. Only 10 percent of respondents stated that they would be willing to bring concerns to the attention of administration and only 25 percent would be willing to request an ethics consultation. Killen (2002) suggested that one of the barriers might be a lack of knowledge. He found that "nurses seem unfamiliar or unaware of institutional policies that might help them to address concerns or problems before an ethical issue arose." In 1987, Parker,

Pratt and Cotton reported the same concern, stating that half of the survey group felt there were no specific resources within the workplace to help resolve ethical problems. The nurses in that study felt that a focus on education by speakers, literature, and consultation would be valuable.

Before education can occur, key ethical concerns need to be identified. Only proper identification can result in appropriately focused education. Studies conducted within the medical professions to identify ethical issues report that issues most disturbing to staff are everyday ethical issues, which are not necessarily those touted in current educational programs or in the media. Johnstone et al. (2004), for example, noted that the following issues were significant to the nurses they surveyed:

- protecting patients rights and human dignity
- providing care with possible risk to their own health
- staffing patterns that limit patient access to nursing care
- the use of physical/chemical restraints
- prolonging the dying process with inappropriate measures
- informed consent
- working with unethical/impaired colleagues
- caring for patients/families who are misinformed
- not considering a patient's quality of life; and
- poor working conditions.

You will note that this list does not include any issues concerning abortion, surrogate motherhood, new reproductive technologies, genetic screening, or cloning.

Hardina, a professor at California State University, found similar findings in her study into ethical issues confronting social workers (2004). Her emphasis was on the fact that many of

the ethical issues faced were not sufficiently addressed in the Code of Ethics of the National Association of Social Workers. This is another example of not providing the resources needed to appropriately address issues faced by medical professionals. Hardina's study identified conflicts of interest associated with financial dealings and dual relationships, conflicts among values, informed consent, and choice of tactics to be key ethical concerns faced by social workers in the field. Informed consent and confidentiality topped the list of ethical issues of concern identified by Kerridge, Pearson, and Rolfe (1998), while those often highlighted by the media, abortion; end-of-life issues; and discrimination, were not considered important. A few years, a study conducted at a Department of Veteran's Affairs hospital found that registered nurses felt the most pressing ethical concern was adequate staffing and appropriate staff dispersion (Smith, Janzen, Schaefer, & Hixon, 2001), while members of the Association of periOperative Registered Nurses identified top concerns as informed consent and quality of care (Killen, 2002).

The Minnesota Nursing Accent, the official publication of the Minnesota Nursing Association, distributed an open-ended survey to nurses. Respondents were asked to write-in what they considered the most important ethical issues facing nursing. The top six most frequently identified were "the allocation and rationing of scare resources; treatment vs. non-treatment; professional role of the nurse; care of the elderly; staffing levels; and public policy." This same study also stressed the need for institutional protocols or mechanisms to assist staff in ethical decision-making (Pearson, 1985). The Kentucky Nurses Association commissioned a similar study in 1987; it garnered slightly different responses. Nurses were given a list of potential ethical health issues and asked to check the three that had the greatest potential for generating ethical dilemmas. The most frequently cited issues were "economics and distribution of scare resources; access to care for medically indigent; treatment vs. non-treatment; care of

elderly patients; and competence in nursing." When asked to check the items that most commonly arise in practice, the top five most often chosen were "documentation; lack of administrative support; code-no-code; compliance to medical treatment; and informed consent for medical treatment" (Parker et al., 1987).

Physicians most commonly seek ethics consultation when "wanting help resolving a conflict; wanting assistance in interacting with a difficult family, patient, or surrogate; wanting help making a decision or planning care; and when emotional triggers are present" (DuVal, Sartorius, Clarridge, Gensler, & Danis, 2001). Physicians have also been affected by managed care, which unveiled organizational ethics concerns that prior to the 1980s were not prevalent. For instance, in 2003, 26 percent of physicians and 30 percent of nurses had exaggerated a patient's medical needs in order to circumvent the managed care pay structure. A majority of the sample population felt that business decisions override patient needs, influencing 78 percent of the respondents to voice concern that the potential for unethical business practices was high (Ulrich et al., 2003).

Delphi Technique

The study design used was a modification of the Delphi method, a quantitative technique developed at the RAND Corporation in the early 1950s (Couper, 1984; Dawson & Brucker, 2001). This method originated as a way to gather expert opinion systematically, and it relies on written responses as opposed to face-to-face contact (Delbecq, Van de Ven, & Gustafson, 1975). The Delphi method is commonly used in the medical and health arenas. It is particularly useful when anonymity is critical, as is the case when discussing ethical issues, particularly in a competitive environment (Fink, Kosecoff, Chassin, & Brook, 1984). In addition, Linstone and Turoff (1975) list several situations when the Delphi method can be applied successfully. Two of

those areas mirror what this study strives to accomplish: "gather current and historical data not accurately known or available" and "expose priorities of personal values, social goals."

The Delphi technique has been used extensively in the health arena to identify skills, knowledge, and abilities needed for various career fields (Hudak, Brooke, & Finstuen, 1994; Hudak, Brooke, Finstuen, & Trounson, 1997). Typically, such studies identify a small number of participants and distribute questionnaires several times until consensus is reached. The method does not necessarily guarantee anonymity, but it makes it possible to ensure responses from the experts. The method also allows solicitation from several participants despite their diverse geographic location (Linstone & Turoff, 1975).

This study, a modification of the Delphi technique, did not seek to identify skills, knowledge, and abilities. Instead, the intent was to garner importance rankings. After the initial responses were organized into domains and areas of concern, the respondents were asked to rank each domain and concern based on its level of importance. Smyth completed a similar study in 2004. Smyth's study sought to determine the relative importance of sources of legal knowledge, skills, and abilities.

Purpose

The purpose of this study is to identify the most important medical ethics concerns faced in greater San Antonio area hospitals. The desire is that this list will assist hospital leadership in identifying ethical issues and, then, in facilitating ethics discussions throughout their organizations, particularly in the form of educational programs.

Method and Procedures

Delphi Round 1 – Ethical Areas of Concern Identification

Study respondents were all hospitals that hold membership in the Greater San Antonio Hospital Council (see Appendix A). The hospital council membership is open to for-profit and not-for-profit short-term facilities, long term facilities, healthcare systems, federal and state facilities, rehabilitation facilities, and ambulatory care institutions. Within the greater San Antonio area, 90-95 percent of the facilities that fall into these categories are members. Skill and expertise were assumed to be traits of all executive level staff, since such positions are obtained through competitive selection boards and strict hiring criteria. Therefore, addressees were those who held executive level positions as chief executive officer, chief medical officer, chief nurse, chief social worker, and administrator at each facility. Although not necessarily "ethics experts," these individuals certainly are, as Sackman (1975) requires "informed…in the target area of inquiry".

The study consisted of two iterations of the Delphi method for executive decision-making separated by an expert panel content analysis. During the first round, referred to as the "exploratory round" by Adler and Ziglio (1996), 136 respondents were asked to participate by a letter of explanation authored by the Greater San Antonio Hospital Council President and CEO, Bill Rasco (see Appendix B). Because of the desire to be inclusive of the entire council membership and, thus, to reach different areas of healthcare, the size of the group was large, which according to Delbecq et al. (1975) is acceptable. The first questionnaire asked respondents to identify five clinical and five organizational areas of ethical concern and associated sub-areas of concern faced at their respective facilities (see Appendix C). Round one information was distributed by email and postal delivery. Returned questionnaires were accepted by email, mail delivery, or fax. All opportunities to market the process were accepted, to include Greater San Antonio Hospital Council membership meetings, the Nursing Executive Forum, the Physician's

Executive Forum, one-on-one meetings with some of Greater San Antonio Hospital Council board members, and city council member "Orientation to the Hospital Council" meetings.

Anonymity of the respondents was protected. The questionnaire packet included a pre-addressed and stamped envelope. If returned by mail, no identifying information accompanied the responses. If the questionnaire was returned by email, the responses were transcribed into a Microsoft Excel spreadsheet prior to deleting the email. Once the email was deleted there was no remaining identifying information. Anonymity was important to encourage response on a controversial topic in a competitive environment. In addition, an atmosphere of non-attribution was essential for obtaining accurate information. The second round of surveys was also sent to the entire original listing of potential respondents, as opposed to sending only to those who responded during the first round.

First Round Analysis – Domains/Compilation of Ethical Areas of Concern List

Following round one, individuals were chosen to serve on the expert panel. The panelists were not chosen at random, but rather in compliance with pre-established criteria (Hasson, Keeney, & McKenna, 2000). The panelists all held a doctorate in a health-care field and had at least two college courses in medical ethics. The panel consisted of two civilians, and one military officer. Bill Ellos, S.J., Ph.D., is a professional ethics consultant, whose work extends outside the U.S. borders. He has worked extensively in the Far East, while also maintaining positions as an ethics professor at the University of Chicago and the University of Texas Health Science Center San Antonio. Henry Perkins, Ph.D., an associate professor of medicine/general medicine at the University of Texas Health Science Center San Antonio, spearheaded the creation of The Center for Ethics and the Humanities in Health Care at the University of Texas Health Science Center San Antonio. For many years he has headed the Ethics and Humanities Journal Club on campus.

His work spans topics such as end of life, surrogate decision-making, and genetic engineering. The federal representative to the panel was Sally Kelly-Rank, Ph.D., CAAMA, a major in the United States Air Force. She was, at the time of the study, the Flight Commander for Resource Management, TRICARE Operations and Patient Administration at Randolph Air Force Base's medical treatment facility. The facilitators for the panel were Karin Zucker, J.D., LLM. and Capt Tracy Allen, USAF, MHA, both of whom had prior experience with expert panels. Professor Zucker teaches Clinical Ethics, Organizational Ethics, and the Law and Ethics of War and Terrorism in the Army Baylor Graduate Program in Health and Business Administration. Captain Allen, a graduate of that program, had formally studied medical ethics.

The panelists reviewed 209 concerns identified in round one of the Delphi. Captain Hurst and Professor Karin Zucker tentatively grouped the areas of concern into 13 clinical domains and 10 organizational domains, prior to the first panelists' meeting. The placement of concerns, as well as the domains, was all subject to change, at the discretion of the panel. The panelists convened for two separate sessions, of which each lasted approximately 4 hours. During the first session the panelists addressed all the clinical domains and concerns. Domain titles were altered; some were deleted and some were added. Areas of concern were moved from one domain to another, as determined by a consensus of the panel members. There were eight clinical domains at the end of the first session. During the second session, the panelists reviewed and validated the organizational domains and concerns, and reduced the number of domains from ten to eight. They also created a societal domain for areas of concern that they determined reached beyond the clinical and organizational domains.

Delphi Round 2 –Ratings

Round two, or the evaluation phase (Adler & Ziglio, 1975), consisted of the original group of 136 participants. Three participants had left the positions they held during the first round and, in those instances, a questionnaire was addressed to the person who had assumed the position, as opposed attempting to reach the original participant. A second letter, authored by Mr. Rasco, was included (see Appendix D). This letter, sent with the second round questionnaire (see Appendix E), explained the status of the project and, once again, requested support from the respondents. Respondents were asked to rank each domain, as established by the expert panel, by degree of importance. Participants ranked the importance of the issues on a 5-point Likert scale, with one equal to "relatively unimportant" and five equal to "extremely important." Respondents were then asked to provide some basic demographic information, to include age, sex, duty title, years of experience, job experience, and years employed at current facility. The demographics are presented in Table 1. This round also included a "yes/no" question that asked whether any value was perceived in having a San Antonio-Wide Ethics Forum. The second round was delivered by email and, if necessary or requested, by postal service. The completed questionnaires were returned primarily by email. As in the first round, upon receipt of the questionnaires, responses were transcribed into a Microsoft Excel spreadsheet and then information identifying the respondents was promptly discarded.

Table 1.

Demographics of the Round 2 Respondents

Variable	No.[a]	Percent
Gender		
Male	20	76.92
Female	6	23.08
Race		
White/Caucasian	22	84.62
Black	1	3.85
Hispanic	2	7.69
Middle Eastern	1	3.85
Age Group		
21-30	2	7.69
31-40	6	23.08
41-50	8	30.77
51-60	10	38.46
Years Experience		
1-10	5	19.23
11-20	8	30.76
21-30	10	38.46
31-40	3	11.54
Years Employed at Current Organization		
0-5	11	42.31
6-10	5	19.23
11-15	3	11.54
16-20	1	3.85
21-25	5	19.23
26-30	1	3.85

[a]Number of respondents who self-identified with each classification or group

Reliability and Validity

Reliability and validity was closely evaluated. Reliability of the measurement tool was assessed using Cronbach's coefficient alpha as shown in Table 2. Content validity was achieved through use of an expert panel of individuals who did not participate as respondents. Construct validity was also achieved through the use of data gathering techniques, procedures, and analyses utilized in other published studies.

Table 2.

Inter-item Reliability Utilizing Cronbach's Alpha Coefficient

Variable	No.[a]	Alpha
Clinical Domains	8	.750
Patient Safety	10	.807
Reproductive Issues	11	.969
Rights/Responsibilities of Staff	19	.903
Staff Conflicts	4	.852
End of Life Care	11	.951
Patient/Proxy Rights	15	.930
Standards of Care	7	.799
Informed Consent	8	.884
Organizational Domains	8	.852
Patient Care	23	.943
Procurement	4	.899
Marketing	9	.912
Financial Aspects of Healthcare	19	.902
Compliance	11	.910
Billing	6	.844
Competition	6	.856
Human Resources	15	.909
Societal Domain	26	.945

[a]Number of items

Analysis

Upon completion of the second round, the results were analyzed. Descriptive statistical analysis was completed utilizing Microsoft Excel and the Statistical Package for the Social Sciences 14.0. The three top ranked areas of concern for both clinical and organizational ethics, as well as the study in its entirety, were presented to the expert panelists and the respondents.

Results

There was a 21.32 percent response rate to the first round of the Delphi study. There was a 19.12 percent response rate to the second round. The second round of questionnaires was much more cumbersome than the first, which may explain the lower rate of response on the second round. Throughout both rounds, reminder emails were distributed to encourage response. Specific individuals who chose not to respond could not be identified, so emails were distributed to the entire sample population each time a reminder was sent.

There were several missing responses. In particular, many participants noted on the questionnaire that their respective facilities do not provide reproductive services and therefore they did not rate concerns within the Reproductive Issues Domain. In the instance of missing data, the affected questions were left incomplete and the descriptive statistics took into account the lower number of responses.

Domain Importance

In the clinical domain rankings, all the domains were rated important, very important, or extremely important, as seen in Table 3. The clinical domains deemed most important were, in order of importance: Patient Safety, Standards of Care, and Informed Consent. Not surprisingly, the Reproductive Issues Domain was deemed the least important of the eight. The standard deviation for the most important three domains was less than one. The area of Reproductive Issues had the greatest range of deviation.

In the organizational domains, each domain was rated at least as important. The top three were Patient Care, Compliance, and Financial Aspects of Healthcare. Competition and Marketing were at the bottom of the list. The standard deviations for the organizational domains were more varied, with Competition's 1.26 being the highest.

The Societal Domain ranked between important and very important. The deviation is greater than many of the other domains, potentially indicating less of a consensus on societal concerns.

Table 3.

Descriptive Statistics for Importance Ratings of Domains

	Mean	S.D.	No.[a]
Clinical			
Patient Safety	4.808	.491	26
Standards of Care	4.480	.714	25
Informed Consent	4.346	.846	26
Patient/Proxy Rights	4.269	.919	26
Rights/Responsibilities of Staff	4.040	.790	25
End of Life Care	4.000	1.095	26
Staff Conflicts	3.615	.941	26
Reproductive Issues	2.654	1.355	26
Organizational			
Patient Care	4.800	.500	25
Compliance	4.560	.712	25
Financial Aspects of Healthcare	3.960	1.098	25
Billing	3.760	1.052	25
Human Resources	3.720	.936	25
Procurement	3.560	.870	25
Marketing	3.280	1.061	25
Competition	3.200	1.260	25
Societal			
Societal	3.560	1.121	25

Note. Importance rating based on a 5-point scale (1=relatively unimportant, 5=extremely important)

[a]Number who responded to the item

Clinical Ethics

Under the Clinical Ethics category, there were 84 separate areas of concern, distributed among eight domains, as listed in Table 3. The respondents ranked each area on a scale of one to five, with one equal to 'relatively unimportant' and five equal to 'extremely important'. Descriptive statistics for the ten most important concerns and ten least important concerns, as identified by the respondents, are provided in Table 4. It is interesting to note that all but two of the top rated concerns fall within one of two domains: Patient Safety or Rights and Responsibilities of Staff. When these domains were ranked, Patient Safety did rank as the most important domain, which mirrored the responses listed here. The Rights and Responsibilities of Staff Domain, however, did not rank at the top. In fact, this domain was ranked fifth of eight domains based on level of importance. The standard deviations associated with the top ranked concerns were low; nine were below one standard deviation.

The areas of concern at the bottom of the rankings primarily fell into the Reproductive Issues Domain. All ten were ranked between important and relatively unimportant. Interestingly, the areas of concern listed as the least important appeared to be those that are often discussed in the national news and highlighted as major ethical concerns by the media and, in some instances, the courts. The ranking deviated more among the lower ranked concerns; each was above one standard deviation, with the highest standard deviation being 1.61.

Table 4.

Descriptive Statistics for Highest and Lowest Rated Clinical Ethics Areas

	Mean	S.D.	No.[a]	Domain
Highest 10 (ranked based on mean)				
Reporting of medication errors	4.760	.523	25	Patient Safety
Reporting suspected abuse of patients	4.538	.706	26	Rights/Responsibility of Staff
Provider/staff misuse of narcotics	4.500	.707	26	Rights/Responsibility of Staff
Staff integrity in interpersonal relationships	4.462	.647	26	Rights/Responsibility of Staff
Assurance of competent staff	4.462	.647	26	Patient Safety
Preserving patient dignity	4.308	.884	26	Patient/Proxy Rights
Adverse drug interactions	4.308	.838	26	Patient Safety
Failure to address patterns of substandard care	4.269	.778	26	Rights/Responsibility of Staff
Protection of privacy/HIPPA	4.231	1.07	26	Patient/Proxy Rights
Patient advocacy	4.200	.764	25	Rights/Responsibility of Staff
Lowest 10 (ranked based on mean)				
Gender selection	1.783	1.242	23	Reproductive Issues
Leftover embryos	1.826	1.370	23	Reproductive Issues
Fertility treatment	1.957	1.261	23	Reproductive Issues
Right to abortion	2.167	1.435	24	Reproductive Issues
Surrogacy/pregnancy	2.217	1.476	23	Reproductive Issues
Identifying the beginning of life	2.292	1.601	24	Reproductive Issues
HIV baby with HIV parent not wanting partner to know	2.375	1.610	24	Reproductive Issues
Fast-track testing of pharmaceuticals	2.462	1.208	26	Patient Safety
Conflict between patients (woman/	2.680	1.520	25	Reproductive Issues

fetus)				
Woman/provider conflicts	2.720	1.568	25	Reproductive Issues

Note. Importance rating based on a 5-point scale
(1=relatively unimportant, 5=extremely important)
[a]Number who responded to the item

Organizational Ethics

The Organizational Ethics category had 92 areas of concern divided into eight domains. The ten most important and ten least important areas of concern are displayed in Table 5. The top five all fell into one of the following domains: Compliance, Marketing, or Billing. The Patient Care and Human Resources Domains appeared as well, when looking at the ten highest. Marketing was not ranked highly when ranked by itself under the domain section of the questionnaire. In fact, Marketing was ranked next to last in importance. Patient Care, however, was ranked as the most important domain, yet it is only reflected twice in the rankings of the areas of concern.

The lowest ten areas of concern fall under Financial Aspects of Healthcare, Human Resources, Competition, Marketing, or Patient Care. Again, the topics often covered in the media are not ranked highly. The issues that seem more important to those in the healthcare field appear to be more "everyday" issues. It seems the respondents would agree with Professor Haavi Morreim (1995), who stated, "Our moral lives are comprised, not of terrible hypotheticals from which there is no escape, but of complex situations whose constituent elements are often amenable to considerable alteration."

The highest standard deviation is associated with refusing care to non-emergent patients who cannot or will not pay. The standard deviation is higher than any of the highest and lowest listings, indicating that this topic is one in which there is a larger degree of argument or perhaps

indecisiveness. At the opposite end is the reporting of medication errors concern, under the clinical ethics category. It had the lowest standard deviation of all those included in the tables, suggesting that almost everyone agrees that it is in fact, an extremely important area of concern.

Table 5.

Descriptive Statistics for Highest and Lowest Rated Organizational Ethics Areas

	Mean	S.D.	No.[a]	Domain
Highest 10 (ranked based on mean)				
Documentation	4.520	.770	25	Compliance
Patients' expectations	4.320	.900	25	Marketing
HIPAA	4.231	.992	26	Compliance
Coding accuracy	4.200	1.155	25	Billing
Data quality reporting	4.200	1.041	25	Marketing
Allocation of resources	4.167	.917	24	Patient Care
Inadequate staffing	4.115	1.033	26	Human Resources
Data quality reporting	4.077	1.129	26	Compliance
Aligning patient care and organizational objectives	4.038	.958	26	Patient Care
Utilization review process	4.000	1.058	26	Patient Care
Lowest 10 (ranked based on mean)				
Inability to provide discounts to patients with insurance	2.250	1.189	24	Financial Aspects
Mergers/Acquisitions	2.391	1.340	23	Financial Aspects
Use of administrative staff as free labor	2.409	1.368	22	Human Resources
Perverse incentives	2.654	1.573	26	Human Resources
Mergers/Acquisitions	2.660	1.375	25	Competition
Recruiting from competing facilities	2.800	1.414	25	Marketing
Churning patients	2.800	1.291	25	Financial Aspects
Refusing care to non-emergent	2.800	1.581	25	Financial Aspects

patients who cannot or will not pay				
Refusing care to non-emergent patients who cannot of will not pay	2.840	1.463	25	Patient Care
Off-loading from the emergency room into services with less access where chronic disease is involved	2.846	1.223	26	Patient Care

Note. Importance rating based on a 5-point scale (1=relatively unimportant, 5=extremely important)

[a]Number who responded to the item

Societal Ethics

The means of the societal areas of concern were lower than those of the other two categories, clinical and organizational, in relation to both the top concerns and the least concerns, as shown in Table 6. The standard deviations are also higher, on average, in comparison to the other categories.

Table 6.

Descriptive Statistics for Highest and Lowest Rated Societal Ethics Concerns

	Mean	S.D.	No.[a]	Domain
Highest 5 (ranked based on mean)				
Care for an aging population	3.654	1.522	26	Societal
Awareness/control of communicable disease	3.640	1.287	25	Societal
Allocation of resources (patient or government)	3.577	1.419	26	Societal
Disaster planning/insufficient surge capacity	3.500	1.334	26	Societal
Rationing healthcare	3.423	1.447	26	Societal
Lowest 5 (ranked based on mean)				
Leftover embryos	1.500	.949	26	Societal
Cloning	1.760	1.234	25	Societal
Right to abortion	1.846	1.377	26	Societal
Genetic/social engineering	1.962	1.248	26	Societal
Stem cell research	2.192	1.600	26	Societal

Note. Importance rating based on a 5-point scale (1=relatively unimportant, 5=extremely important)

[a]Number who responded to the item

San Antonio-Wide Ethics Forum

The majority of respondents believed that their respective organization would benefit from a San Antonio ethics forum. Fifteen respondents, 58 percent, stated 'yes' to the question. Another six respondents, 23 percent, were unsure, stating responses such as 'maybe' and 'don't know'. Only five, 19 percent, did not believe that an area-wide ethics forum would be beneficial.

Discussion

The demographics section of the study reveals that the executive level staff at hospitals in and around San Antonio is 85 percent Caucasian and 77 percent male. Despite the fact that 52 percent of San Antonio residents are Hispanic, the top positions in the healthcare industry are occupied by Caucasians. The demographics also reveal that there is a high turnover rate among healthcare executives; 43.12 percent have been employed at their current location for 5 or fewer years. Approximately 81 percent of respondents have between 11 and 40 years of experience.

The most interesting finding that came from the ranking of domains and areas of concern was the fact that the high profile issues do not rank as very important in the eyes of the respondents. Instead, common issues are considered more important. The expectation was that the media would influence the respondents to some extent, which did not appear to be the case. In fact, the End-of-Life Domain and all its associated areas of concern did not appear in the top ten at all, despite the fact that end of life concerns are consistently highlighted in the media. As a domain, End-of-Life, ranked sixth out of eight.

An encouraging finding appeared in the domain rankings. Patient Safety, under the clinical category, and, Patient Care, under the organizational category, ranked the highest in their respective areas. This indicates that each of the executives, who responded, whether they were administrative or clinical, placed the patient at the center of the picture. Administrators are often accused of being paper driven or narrowly focused on the financial aspects of healthcare. These results, however, indicate otherwise.

Various reporting concerns rank high in both the clinical and organizational areas. Reporting of medication errors, reporting of suspected abuse of patients, and data quality reporting rank among the most important concerns. This suggests that the move for more

transparency is probably in line with what many healthcare executives desire. If the transparency movement progresses; and, reporting of errors, abuse, quality problems and the like becomes more common and less subject to criticism, across the industry, then these areas will likely become less important.

The Reproductive Issues concerns ranks surprisingly low. Despite a recent focus on abortion and Capitol Hill's debate on stem cell research, healthcare leaders do not see these areas of concern as important at their respective facilities. These, along with End-of-Life concerns, may be areas in which hospital leadership can be proactive. As long as these topics appear in the media, patients will be versed on them, which suggests a lack of congruence between what hospital leadership deems important and what patients deem important.

Limitations

The complicated subject matter of this study was itself a limitation. Ethics has numerous definitions. Without significant training in the field of ethics, it is hard even to identify a concern or an issue as an ethical one rather than, for example, one of communication or compliance. This may have contributed to the low response rate. It also led to some ambiguous responses that had to be significantly rephrased by the expert panel. Although panel members reached consensus on any rephrasing of responses, there was still no guarantee that the intent was not altered.

A second limitation was the length of the second round of questionnaires. To maintain the integrity of the study all of the categories were re-distributed to include the additional Societal Domain. This resulted in a 9-page questionnaire. The most common comment on the second round was that the document was too long. Again, the length probably negatively impacted the response rate, and potentially the quality of the responses. According to Bowles (1999), a low response rate contributes to sample bias, as well.

A third limitation was the fact that not all areas of concern, or domains, were applicable to each facility. As a result, many respondents skipped entire sections. The Reproductive Issues section, for instance, was left blank on a few questionnaires since the respondent was not at a facility that dealt with reproductive services.

Conclusion and Recommendations

Overall the study presents useful data. Now, there is a concise listing of the top areas of ethical concern (clinical, organizational, and societal) in the greater San Antonio area. Everyday issues are the most important to healthcare executives in the San Antonio area. Many previous studies throughout the United States, as well as internationally identified similar findings (Johnstone et al., 2004; Hardina, 2004; Smith et al., 2001; Penticuff & Walden, 2000; Kerridge et al., 1998; Killen, 2002; Du Val et al., 2001; Pearson, 1985; Parker et al., 1987). As a result, leadership should prepare their staffs accordingly, placing increased emphasis on the areas found in this study and others as identified through internal review.

Additional studies should be conducted to identify ethical areas of concern in specialized sectors of the healthcare industry. For instance, targeting long term care facilities might render completely different results than those developed in this study. End-of-life concerns, such as palliative care, might well be at the forefront of long-term care facilities' importance listing. Even studying tertiary care facilities by product lines would be useful. Those which have reproductive services could be one targeted group; those with pediatric oncology another; and those with long term inpatient psychiatry yet another.

Also, exploratory studies related to ethics in the future could target frontline workers, as opposed to executives, who interact less with the patient and the families. Floor nurses, or medical residents, on the other hand, have significant interaction and, as a result, might respond

differently. Patients are regularly bombarded with the media's take on high-profile issues, yet they often lack the medical knowledge to be able to thoroughly understand the issues. Therefore, frontline providers may rank societal issues higher since they are in contact with the patients, who may be voicing media-fueled concerns or asking questions pertaining to the latest news story.

Regardless of what study is undertaken next, the findings resulting from this study should be incorporated into hospital training programs now. Education on ethical decision-making and on the most important ethical concerns can be refined. Tailoring education to the areas of particular importance in San Antonio will make ethics training more pertinent. Coupling targeted education on particular areas with specific tools, such as ethical decision-making models, will empower staffs to make informed, and better decisions in the future (Ross, 1986).

There are several popular ethical decision-making models available that might be useful to assist leaders and employees when confronted with an ethics decision to make. One is the Baylor 7-Step Method, which is particularly useful when facing clinical ethical issues. The modified Baylor 7-Step Method adds emphasis and depth that makes it most useful for organizational ethics discussion (Methods, 2004). In addition, there are the methods of Beauchamp and Childress (Beauchamp & Childress, 2001), Weber (Weber, 2001), and Fletcher (Fletcher, 1997). Any of these tools can be employed organization-wide. With focused education and proper tools, providers will gain confidence in ethical decision-making, which will benefit the patient and the families.

Disclaimer

The conclusions presented in this study are the opinions of the researcher and do not reflect the opinions or judgments of the Greater San Antonio Hospital Council, the United States Army, the United States Air Force, or the Department of Defense.

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Appendix A – Greater San Antonio Hospital Council Membership Listing

(as of May 2005)

Baptist Health System

Brooke Army Medical Center

CHRISTUS Santa Rosa

CHRISTUS Santa Rosa Children's Hospital

Connally Memorial Medical Center

Great Plains Regional Medical Command

Guadalupe Valley Hospital

HEALTHSOUTH RIOSA

Kindred Hospital San Antonio

LifeCare Hospitals of San Antonio

McKenna Healthcare System

Medina Community Hospital

Memorial Hospital

Methodist Ambulatory Surgery Center

Methodist Hospital

Metropolitan Methodist Hospital

Nix Health Care System

North Central Baptist Hospital

Northeast Baptist Hospital

Northeast Methodist Hospital

Otto Kaiser Memorial Hospital

Select Specialty Hospital San Antonio

Seton Edgar B. Davis Memorial Hospital

South Texas Regional Medical Center

South Texas Veteran's Health Care System

Southeast Baptist Hospital

St. Luke's Baptist Hospital

TexSan Heart Hospital

Texas Center for Infectious Disease

Texas Specialty Hospital at San Antonio

The Spine Hospital of South Texas

University Health System

University Hospital

Uvalde Memorial Hospital

Warm Springs Rehabilitation Center

Wilford Hall Medical Center

Appendix B – Initial Delphi Letter

September 22, 2005

«««AddressBlock1»»»
«««AddressBlock»»»

Dear «««GreetingLine»»»,

As you are aware, the Hospital Council staff is continuously seeking new ways to provide benefit to your organization. We are now initiating the **"Study of Medical Ethical Areas of Concern in the San Antonio Area" to pinpoint clinical and organizational ethical concerns faced by our member hospitals**. The results of this region-specific study will be returned to you along with accompanying educational and training materials. You are in a unique position to understand many of these concerns. As a result, we are asking that you, along with your fellow executives respond to the study. A similar letter and instrument will be sent to each person individually seeking his/her support.

The questionnaire **will take approximately 10 minutes to complete**. The study design is a modified Delphi technique, which consists of two-parts. The questionnaire consists of only two questions initially. After all responses are compiled, you will then be asked to rank them in order of importance. The key is to garner a high response rate and robust responses. We are asking for you to help make this study a success by encouraging response from your organization by **October 7, 2005**.

A booklet including a consolidated list of current and anticipated ethical concerns faced in hospitals will be provided to you when the study is complete. It will also include current research and associated case studies. **The booklet will be designed as a training tool for your Ethics Committee and staff.**

The attached questionnaire will also be sent to you by email. Whether you chose to return the questionnaire using the pre-addressed/stamped envelope or by email, **your identity will not be associated with your responses**. The questionnaires will be aggregated by our graduate student resident, Laura Hurst. She will immediately shred any identifying information after recording the responses. If you have reservations concerning this method or if you have questions, please call her at 820-3500 ext 15 or me at ext 13.

Thank you for your support of the Hospital Council and particularly for your help in making this study a success.

Sincerely,

Bill Rasco, FACHE
President and CEO

Appendix C – Round 1 Questionnaire

Instructions

First – List in the left column what you personally consider the TOP FIVE clinical and then organizational ethical areas of concern faced at your facility. Explain as clearly as possible, making sure to avoid generalized or categorical terms.

Second – List in the right column the related sub-areas of concern. You may consult others to develop your responses. Explain as clearly as possible, making sure to avoid generalized or categorical terms.

Third – Return your responses in the enclosed pre-addressed/stamped envelope or to one of the following e-mail addresses on or before October 7, 2005:

resident2@gsahc.org or laura.hurst@amedd.army.mil

Top Five Clinical Ethics Areas of Concern	Related Sub-Areas of Concern
Example: End of Life	Example: terminal sedation, lack of advanced directives
1.	
2.	
3.	
4.	
5	

Top Five Organizational Ethics Areas of Concern	Related Sub-Areas of Concern
Example: Financial Solvency	Example: upcoding, collection techniques, uncompensated care
1.	
2.	
3.	
4.	
5.	

Appendix D – Round 2 Delphi Letter

January 16, 2006

«AddressBlock1»»
«AddressBlock»»

Dear «GreetingLine»»,

As you are aware, the Hospital Council staff is conducting the **"Study of Medical Ethical Areas of Concern in the San Antonio Area" to pinpoint clinical and organizational ethical concerns faced by our member hospitals**. We greatly appreciate your response to the first round! From the responses we have compiled the attached second and final questionnaire. We are asking that you, along with your fellow executives respond once more. A similar letter and instrument will be sent to each person individually seeking his/her support.

The questionnaire **will take approximately 15 minutes to complete**. The questionnaire consists of each of your initial responses. They have been grouped into domains and slightly edited by a 3-person expert panel. We need you to rank them in order of importance. The key is to garner a high response rate and robust responses. We are asking for you to help make this study a success by encouraging response from your organization by **February 1, 2006**.

A booklet including a consolidated list of current and anticipated ethical concerns faced in hospitals will be provided to you when the study is complete. It will also include current research and associated case studies. **The booklet will be designed as a training tool for your Ethics Committee and staff.**

The attached questionnaire will also be sent to you by email. Whether you chose to return the questionnaire using the pre-addressed/stamped envelope or by email, **your identity will not be associated with your responses**. The questionnaires will be aggregated by our graduate student resident, Laura Hurst. She will immediately shred any identifying information after recording the responses. If you have reservations concerning this method or if you have questions, please call her at 820-3500 ext 15 or me at ext 13.

Thank you for your support of the Hospital Council and particularly for your help in making this study a success.

Sincerely,

Bill Rasco, FACHE
President and CEO

Appendix E – Round 2 Questionnaire

Clinical Ethics

Please rate each of the following domains by the level of ethical importance in your organization:

	relatively unimportant	somewhat important	important	very important	extremely important
Patient Safety	1	2	3	4	5
Reproductive Issues	1	2	3	4	5
Rights/Responsibilities of Staff	1	2	3	4	5
Staff Conflicts	1	2	3	4	5
End of Life Care	1	2	3	4	5
Patient/Proxy rights	1	2	3	4	5
Standards of Care	1	2	3	4	5
Informed Consent	1	2	3	4	5

Each of the following areas is associated with "Patient Safety". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
poly-pharmacy	1	2	3	4	5
adverse drug interactions	1	2	3	4	5
reporting of medication errors	1	2	3	4	5
unnecessary procedures and diagnostic tests	1	2	3	4	5
assurance of competent staff	1	2	3	4	5
compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA)	1	2	3	4	5
nosocomial infections	1	2	3	4	5
failure to provide patient education	1	2	3	4	5
failure to appropriately address patterns of substandard care	1	2	3	4	5
fast-track testing of pharmaceuticals	1	2	3	4	5

Each of the following areas is associated with "Reproductive Issues". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
nurturing impaired infants/neonates	1	2	3	4	5
conflict between patients (woman/fetus)	1	2	3	4	5
right to abortion	1	2	3	4	5
infant's quality of life	1	2	3	4	5
woman/provider conflicts	1	2	3	4	5
identifying the beginning of life	1	2	3	4	5

surrogacy/pregnancy	1	2	3	4	5
gender selection	1	2	3	4	5
leftover embryos	1	2	3	4	5
HIV baby with HIV parent not wanting partner to have knowledge of such	1	2	3	4	5
fertility treatment	1	2	3	4	5

Each of the following areas is associated with "Rights/Responsibilities of Staff". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
staff integrity in interpersonal relationships	1	2	3	4	5
self/family-prescribing and self/family-treatment	1	2	3	4	5
defensive medicine	1	2	3	4	5
abuse of staff by staff	1	2	3	4	5
provider/staff misuse of narcotics	1	2	3	4	5
coding accuracy	1	2	3	4	5
reporting suspected abuse of patients	1	2	3	4	5
legal knowledge	1	2	3	4	5
patient education	1	2	3	4	5
cultural awareness/respect for culture	1	2	3	4	5
physician not seeing patients before procedure/surgery	1	2	3	4	5
disclosure of pertinent health information (staff health issues i.e. AIDS)	1	2	3	4	5
timeliness of response to patient needs by on-call physician	1	2	3	4	5
patient advocacy	1	2	3	4	5
disclosure to patients of care option costs	1	2	3	4	5
formal oversight of healthcare providers	1	2	3	4	5
failure to appropriately address patterns of substandard care	1	2	3	4	5
number of procedures/expertise	1	2	3	4	5
communicating with family	1	2	3	4	5

Each of the following areas is associated with "End of Life Care". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
futile treatment	1	2	3	4	5
problems with, or lack of, advanced directives: Do Not Resuscitate (DNR), Living Will, Power of Attorney (POA) for health care	1	2	3	4	5
withdrawal of care verses withholding of care	1	2	3	4	5

withdrawal of nutrition/hydration	1	2	3	4	5
obligation to provide aggressive care only because there is no expression to the contrary	1	2	3	4	5
physician conflicts with the philosophy of hospice	1	2	3	4	5
making judgments on quality of life	1	2	3	4	5
euthanasia	1	2	3	4	5
physician willingness to talk with patient/timeliness	1	2	3	4	5
problems with Texas state law regarding end of life care	1	2	3	4	5
proxy decision-makers	1	2	3	4	5

Each of the following areas is associated with "Patient/Proxy Rights". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
patients' refusal of care/non-compliance	1	2	3	4	5
patient's management/physician reluctance	1	2	3	4	5
patients' need for education/understandable information geared toward patients' education level	1	2	3	4	5
parental ability to refuse care for children	1	2	3	4	5
challenges to patient's competency by physicians who disagree with patient's choice	1	2	3	4	5
freedom from parentalistic care	1	2	3	4	5
patient/family input into care	1	2	3	4	5
preserving patient dignity	1	2	3	4	5
timeliness of response to patient needs by on-call physicians	1	2	3	4	5
patient advocacy	1	2	3	4	5
physicians consent/ effect of statutory conscious clauses	1	2	3	4	5
protection of privacy/Health Insurance Portability and Accountability Act (HIPAA)	1	2	3	4	5
personal health information of staff	1	2	3	4	5
minors rights to self-determination	1	2	3	4	5
proxy decision-makers	1	2	3	4	5

Each of the following areas is associated with "Standards of Care". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
care for unfunded patients	1	2	3	4	5

adequate pain medication/physician's fear of patient's addiction or death	1	2	3	4	5
defensive medicine	1	2	3	4	5
physician not seeing patients before procedure	1	2	3	4	5
unnecessary procedures and diagnostic tests	1	2	3	4	5
compliance with accreditation standards/guidelines	1	2	3	4	5
poly-physician (continuity of care)	1	2	3	4	5

Each of the following areas is associated with "Informed Consent". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
physician's challenging patient competency	1	2	3	4	5
determination of patients' competency	1	2	3	4	5
disclosure of full range of financial options	1	2	3	4	5
non-consensual treatment	1	2	3	4	5
patient's refusal of care	1	2	3	4	5
communicating with patients in a way that they can understand	1	2	3	4	5
language (translators)	1	2	3	4	5
lack of specified decision-maker	1	2	3	4	5

Each of the following areas is associated with "Staff Conflicts". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
conflicts with corporate sponsors	1	2	3	4	5
staff/nurse abuse by physicians	1	2	3	4	5
disagreement over care decisions	1	2	3	4	5
lack of common objectives between physicians and administrators	1	2	3	4	5

Organizational Ethics

Please rate each of the following domains by the level of ethical importance in your organization:

	relatively unimportant	somewhat important	important	very important	extremely important
Patient Care	1	2	3	4	5
Procurement	1	2	3	4	5
Marketing	1	2	3	4	5
Financial Aspects of Healthcare	1	2	3	4	5

Compliance	1	2	3	4	5
Billing	1	2	3	4	5
Competition	1	2	3	4	5
Human Resources	1	2	3	4	5

Each of the following areas is associated with "Procurement". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
formal material/purchasing policies or regulations	1	2	3	4	5
gifts to employees	1	2	3	4	5
informal/non-codified influences on purchase decisions	1	2	3	4	5
rationale for bidding/awarding contracts	1	2	3	4	5

Each of the following areas is associated with "Marketing". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
misleading advertising or publicity	1	2	3	4	5
mergers/acquisitions	1	2	3	4	5
recruiting from competing facilities	1	2	3	4	5
targeting proper/defined community (segmentation)	1	2	3	4	5
competing based on the latest technology	1	2	3	4	5
vendor/staff relationships	1	2	3	4	5
vendors influence on practice choices	1	2	3	4	5
data quality reporting	1	2	3	4	5
patients' expectations	1	2	3	4	5

Each of the following areas is associated with "Patient Care". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
lack of Emergency Department coverage	1	2	3	4	5
diversion	1	2	3	4	5
length of stay management	1	2	3	4	5
clinical verses organizational discharge planning	1	2	3	4	5
corporate influence on decisions	1	2	3	4	5
barriers to accessing services	1	2	3	4	5
physician/family relationships	1	2	3	4	5
discharging patient for physician convenience	1	2	3	4	5
discharging pt for family convenience	1	2	3	4	5

allocation of resources	1	2	3	4	5
Emergency Medical Treatment and Active Labor Act (EMTALA)/dumping	1	2	3	4	5
prolonging life at all costs	1	2	3	4	5
ensuring Medicare/Medicaid patients have true choice in providers and facilities during course of illness	1	2	3	4	5
off-loading from the Emergency Department into services with less access where chronic disease is involved	1	2	3	4	5
refusing care to non-emergency patient who cannot or will not pay	1	2	3	4	5
risk-benefit analysis (futile care)	1	2	3	4	5
malingering/hypochondriac	1	2	3	4	5
upcoding	1	2	3	4	5
rationing of necessary services from patient to patient (bed-side rationing)	1	2	3	4	5
utilization review process	1	2	3	4	5
aligning patient care and organizational objectives	1	2	3	4	5
keeping decisions in the order of "what's best for clients," "what's best for the organization", "what's legal," and finally "what can I live with?"	1	2	3	4	5
organizations who accept patients who do not meet criteria for the level of care	1	2	3	4	5

Each of the following areas is associated with "Compliance". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
Emergency Medical Treatment and Active Labor Act (EMTALA)	1	2	3	4	5
data quality reporting	1	2	3	4	5
self-referral/Stark regulations	1	2	3	4	5
documentation	1	2	3	4	5
Health Insurance Portability and Accountability Act (HIPAA)	1	2	3	4	5
faking compliance to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and to meet Medicare requirements	1	2	3	4	5
increase in technology expected, but unfunded and expensive	1	2	3	4	5
lack of legal and ethical knowledge by staff	1	2	3	4	5
excellence verses compliance	1	2	3	4	5
slow adoption of best practice guidelines	1	2	3	4	5
wrongful use of hospital owned materials	1	2	3	4	5

Each of the following areas is associated with "Billing". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
coding accuracy	1	2	3	4	5
hidden cost of care	1	2	3	4	5
patient bills are not understandable	1	2	3	4	5
reimbursement issues	1	2	3	4	5
inability to provide discounts to patients with insurance	1	2	3	4	5
collection practices	1	2	3	4	5

Each of the following areas is associated with "Competition". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
physician self-referral	1	2	3	4	5
physician -owned specialty hospitals	1	2	3	4	5
exceptional care verses standard care	1	2	3	4	5
competing based on the latest technology	1	2	3	4	5
mergers/acquisitions	1	2	3	4	5
managed care contracts setting reimbursement rates lower than the Centers for Medicare and Medicaid Services (CMS)	1	2	3	4	5

Each of the following areas is associated with "Financial Aspects of Healthcare". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
allocation of and decline of capital/resources (e.g. infrastructure suffers due to lack or resources)	1	2	3	4	5
uncompensated care	1	2	3	4	5
prolonging life at all costs	1	2	3	4	5
excessive allocation of budget to non-clinical areas	1	2	3	4	5
limited options for care after the acute phase due to lack of funding	1	2	3	4	5
churning patients	1	2	3	4	5
inability to provide discounts to patients with insurance	1	2	3	4	5
limited resources to develop community support services	1	2	3	4	5
paying for long-term patient stays	1	2	3	4	5
wrongful use of hospital owned materials	1	2	3	4	5

increase in technology expected, but unfunded and expensive	1	2	3	4	5
appropriate patient selection verses financially needed mix	1	2	3	4	5
utilization review process	1	2	3	4	5
managed care contracts setting reimbursement rates lower than the Centers for Medicare and Medicaid Services (CMS)	1	2	3	4	5
cost-benefit analysis	1	2	3	4	5
corporate-level rationing of healthcare	1	2	3	4	5
mergers/acquisitions	1	2	3	4	5
refusing care to non-emergent patients who cannot or will not pay	1	2	3	4	5
funding of Graduate Medical Education (GME)	1	2	3	4	5

Each of the following areas is associated with "Human Resources". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
use of administrative staff as free labor	1	2	3	4	5
staff salaries and pay (e.g. pay for tenured/loyal staff verses hire-on pay for new employees; clinical staff salaries; as physician reimbursement flattens or falls hospitals give stipends; compression adjustments; market adjustments; perks for staff such as free meals or travel not counted as vacation time; other)	1	2	3	4	5
dealing with harassment (e.g. verbal, sexual, intimidation, other)	1	2	3	4	5
staff diversity to match patient population	1	2	3	4	5
management-labor relations	1	2	3	4	5
organizational policies and application of policies	1	2	3	4	5
insufficient cultural/religious sensitivity or competence	1	2	3	4	5
peer review process	1	2	3	4	5
perverse incentives (e.g. rewarding top admitters; penalizing low admitters; other)	1	2	3	4	5
credentialing	1	2	3	4	5
conflicts of interest (e.g. gifts from vendors; nepotism; use of information gained in Institutional review Board (IRB); other)	1	2	3	4	5
loyalty issues	1	2	3	4	5
inadequate staffing	1	2	3	4	5

dependence on contract staff (e.g. ability to control; knowledge of organization; currency of skills; other)	1	2	3	4	5
inadequate resources for staff education and training	1	2	3	4	5

Societal Ethics

Please rate the following domain by the level of ethical importance in your organization:

	relatively unimportant	somewhat important	important	very important	extremely important
Societal	1	2	3	4	5

Each of the following areas is associated with "Societal Ethics". Please rate each by its level of ethical importance in your organization.

	relatively unimportant	somewhat important	important	very important	extremely important
public funding for chronic care	1	2	3	4	5
identifying the beginning of life	1	2	3	4	5
genetic engineering/social engineering	1	2	3	4	5
rationing healthcare (e.g. ability to pay; compliance; age; other)	1	2	3	4	5
legality and morality of euthanasia	1	2	3	4	5
awareness/control of communicable disease	1	2	3	4	5
fast-track testing of pharmaceuticals	1	2	3	4	5
stem cell research	1	2	3	4	5
cloning	1	2	3	4	5
use of 3rd world populations for pharmaceutical testing	1	2	3	4	5
parental ability to refuse vaccines for children	1	2	3	4	5
barriers (e.g. financial or knowledge based; real or perceived; other) to access	1	2	3	4	5
vendor/physician relationships	1	2	3	4	5
physician-founded specialty hospitals	1	2	3	4	5
integration of hospital care with public health	1	2	3	4	5
disaster planning/insufficient surge capacity	1	2	3	4	5
lack of research funding	1	2	3	4	5
allocation of resources (patient or government)	1	2	3	4	5
care for an aging population	1	2	3	4	5
lack of specialty coverage in Emergency Department due to poor reimbursement and litigation concerns	1	2	3	4	5
limited resources for community services	1	2	3	4	5

care of non-US. citizens	1	2	3	4	5
leftover embryos	1	2	3	4	5
right to abortion	1	2	3	4	5
financial support lacking from outlying counties	1	2	3	4	5
ensuring Centers for Medicare and Medicaid Services patients have true choice in providers and facilities	1	2	3	4	5

Demographic and Poll Questions

What is your gender?	
What is your age?	
What is your race?	
How many years of experience do you have in the healthcare industry?	
How many years have you been employed at your current organization?	
Do you believe that your organization would benefit from participating in a greater San Antonio medical ethics forum?	

Comments

At the conclusion of the study, case studies dealing with the most important areas will be compiled. If there is an ethical area of particular importance to your organization that was not addressed in the previous importance scales, please write about it in the space below. We will attempt to include an additional case study to address the identified issue.

Thank you for your participation! We look forward to providing you a summary of the study soon.

Appendix F – Raw Data (Round 1)

Round 1 – Clinical Responses

		a	b	c	d	e	f
	Clinical Ethics Areas of Concern	**Related Sub Area 1**	**Related Sub Area 2**	**Related Sub Area 3**	**Related Sub Area 4**	**Related Sub Area 5**	**Related Sub Area 6**
1	medical staff peer review	failure to appropriately address patterns of substandard care					
2	slow adoption of national patient safety recommendations	abbreviations	time outs				
3	slow adoption of best practice guidelines						
4	polypharmacy						
5	care for unfunded patients						
6	futile treatment	lack of in-depth communication					
7	discrepancies in reimbursement	procedure v. cognitive ("doing something" equals reimbursement)					
8	physicians and hospitals are not always aligned	hospitals are paid by DRG; docs paid per diem					
9	higher allocation of budget to nonclinical areas	higher oversight	higher need for coding	documentation	finance	admitting	risk
10	end of life	lack of advanced directives	vent/dialysis patients	futile care			
11	discharge placement	lack of patient choice	physician directed referrals				
12	patient/family input into care	dysfunctional family dynamics	no clear power of attorney				
13	medication management	polypharmacy	use of narcotics				
14	utilization review	peer review process for physicians					
15	EMTALA						
16	charity (unfunded)						
17	HIPPA						
18	advanced directives						
19	vendor/physician relationships						
20	advanced directives						
21	HIPPA						

22	vendor/physician relationships						
23	charity						
24	EMTALA						
25	public reporting of medication errors	interpretation of "error": Is it an error if the wrong medication delivered by the hospital pharmacy is caught by the nurse before being given to the patient?					
26	end of life	rights/responsibilities of staff in assisting					
27	allowing company reps in OR	how determine level of involvement in cases					
28	termination of pregnancy procedures	rights/responsibilities of staff					
29	physician malfeasance	allowing physician to practice under staff-reported suspicions of improper care					
30	DNR	lack of physician support to make timely decisions on agreeing or disagreeing with family on patient desires					
31	end of life	supporting advanced directives	decisions about removal of life support	physicians willingness to talk with family			
32	informed consent	finding the appropriate person to give informed consent	insuring the patient and/or family have been fully informed	having family available at the time of OR to confirm that correct procedure has been consented for			
33	continuation of psychiatric meds	interruption of long term psych meds may create significant problems for patient					
34	surrogacy	consent	family relationships				
35	end of life	advanced directives or lack of conflicting interest of family					
36	adequate pain medication	drug addiction	conflict of patient's pain perception vs. physician				
37	children with conflict regarding custodial parent						

38	HIV baby and parent with HIV not wanting partner to have knowledge of such	privacy					
39	determination of appropriate tx for drug addiction (i.e. Long term IV antibiotic)	rights and responsibilities of pt	non-compliance with tx plan	discharge of patient from care			
40	consent for non-emergent treatment when pt lacks capacity and has no known family	contributes to increase inpatient stay	inability to tx preventively	result is to tx emergently	limited resources of Adult Protective Services to intervene		
41	determination of appropriate intervention/tx for pain	liability contributing to "addiction" vs. inadequate relief					
42	lack of medical power of attorney or advanced directives combined with complexities of family relationships (i.e. Common law, same sex partners)	increased utilization of Ethics Committee to attempt determination of "legal surrogate: as defined in the Texas Health and Safety Code.	limited legal guidelines				
43	aging Bexar Co. jail population with increase of medical infirmities needing intervention	increased utilization of resources and additional financial concern to BCHD					
44	care of a cancer patient in ER when advanced directive unknown	intubate?					
45	responsibility of staff when surgeon scheduling case is questionably competent - staff feel patient should be transferred	small medical staff, only on general surgeon who thinks he can do anything	no valid credentialing process				
46	futility of care	ability to transfer pt. to a willing provider					
47	futility of care (10 day rule)	procedural steps for utilizing 10-day rule without family's agreement					
48	state law end of life	state requirements vary from corporate requirements (corporate more stringent)					

49	withdrawal of ventilator support	medical staff documentation in relation to the law					
50	education re: advanced directive and DNR	confusion related to the differences (pt/family)					
51	futility of resource XXX[a]	90 percent of resources paid out in last 30 days of patients life					
52	conflicts with corporate sponsors	fending off influence of direct XX[a] patients XXX[a]					
53	staff integrity: interpersonal relationships	conflicts with therapeutic relationships					
54	end of life pain control	euthanasia vs. compassion					
55	self prescription/self treatment	of/by practitioners/family					
56	poly physician	multiple admits	poly pharmacy				
57	cost of care v. gain or futile effort						
58	placing gastric tubes in dying patients or colonoscopy on a 95 year old	surgeons willing/eager to perform procedures					
59	end of life	advance directive	right to die				
60	patient finances	patients/families not always informed about less expensive options					
61	patient education level	pts often do not understand what is happening	poor communication with patient				
62	staff/nurse abuse	physician conduct					
63	physician to seeing patients before procedures/surgery	patients having procedures and surgery with seeing physicians before hand					
64	end of life	definitions of futile care	euthanasia for "society's best interest" to reduce Medicare expenditures, other social interests, dicrimatory behaviors				
65	chronic care	access, availability, measures of quality for chronic care/supplies/pharmaceuticals	infectious communicable disease awareness/controls	public health funding			

66	beginning of life	abortion on demand, gender planning with ultrasound	stem cell research	genetic/social engineering			
67	genetic engineering	attempts to "clone" humans	inadequate testing of pharmaceuticals	3rd world pharmaceutical abuses			
68	recurrence of epidemic infectious and communicable diseases	only know AIDS for 30 years - what's next?	influenza	recurrence of vaccine preventable diseases			
69	timeliness of response to patient needs by on call physicians						
70	physician founded specialty hospitals	transfer of patients from one facility to another					
71	end of life						
72	unnecessary procedures						
73	compliance with guidelines						
74	end of life	PEG tube placement					
75	consent to treat	family conflict and decision making (multiple opinions)	family/patient conflict (when does medical POA become effective)				
76	discharge planning	conflict issues (when patient is ready to discharge)	placement issues (when patients can't receive care needed at home)				
77	informed consent - end of life issues	advanced directives - having complete advanced directives of advance directives with ambiguous directions	family not present on admission	determining when patient can sign	POA signing but patient is competent	common law situations - TX law	
78	Quality of Life (LTCH pts)	patient preferences - "please let me die"					
79	Pts refusal of care - medicinal use	pt rights					
80	continuity of care	continued fragmented communication between levels of care/physicians					
81	patient safety and quality of care	dependence on contract staff to fill vacancies and provide care					
82	best practices/protocols for post acute care settings						

83	physician accountability	compliance with safety and accreditation standards	dependence on hospital staff to follow lab values, test results, etc.				
84	resources for staff education and training						
85	advanced directives	lack of understanding	surrogate decision making	education of community - to remove from crisis mode decision making	dignity of patient		
86	DNR	physician cooperation with DNR directives from family	continuation of treatment when the benefit is very minimal	dignity of the patient			
87	competency of patient	who and how that is determined	request from physicians to challenge competency of patients when patient refuses care	dignity of the patient			
88	informed consent	relating to cultural and language competency to ensure that the patient know what they are consenting to	paternalistic sense in terms of healthcare providers deciding what is best for the patient	dignity of the patient			
89	nutrition/hydration issues	confusion for the general public	recent media coverage putting healthcare providers in a bind when deciding nutritional/hydration needs				
90	over utilization of diagnostic tests	ordering test for fear of liability issues	ordering tests by physicians in facilities that they own	ordering tests on Hospice patients			
91	physician peer review	adequacy of patient safety					
92	rationing healthcare	based on ability to pay	willingness to change unhealthy behaviors				
93	end of life	prolonging death thru passive/aggressive therapy					

94	maternal/fetal issues at threshold of viability						
95	end of life	clarification to families about having directives					
96	lab testing	testing patient for unnecessary labs					
97	patient advocacy	regarding procedures not always for the best interest of the patient					
98	end of life	lack of advanced directives	lack of referral to hospice				
99	elder abuse	lack of attention or care by family (i.e. keeping at home)					
100	unnecessary treatments/tests	many of these are done to avoid liability					
101	financial status of patient	patients/families do not always get informed fully about the…					
102	financial issues	pts not seeking treatment due to inability to pay					
103	limited education	pts don't always understand self					
104	end of life	lack of advanced directives					
105	personal health info of patients	we know pts and staff outside work					
106	personal health info of staff	everyone knows (make up of community)					
107	registration/ED/DS	dividers do not prevent overhearing					
108	end of life	no advanced directives					
109	abuse to staff	physicians conduct					
110	patients educational level	due to their education level do not really understand what is happening to them					
111	physicians/consent	physicians not getting the consent					
112	physician not seeing patients before procedure	not visiting with the patient before sedation or anesthesia for procedure or surgery					

[a]Response was illegible. Undecipherable responses were not reviewed in the expert panel process.

Round 1 – Organizational Responses

	a	b	c
Organizational Ethical Areas of Concern	**Related Sub Area 1**	**Related Sub Area 2**	**Related Sub Area 3**

1	physician self-referral	joint ventures or physician wholly owned ventures		
2	EMTALA	both dumping and reverse dumping		
3	upcoding			
4	accreditation	hospitals faking compliance to JCAHO and Medicare		
5	financial solvency	huge problem with uninsured and underinsured in our area		
6	lack of ER specialty coverage	docs more unwilling to cover - poor reimbursement, litigation concerns		
7	high regulatory oversight			
8	allocation of capitol	always more needs than dollars - infrastructure suffers		
9	supporting physicians financially by the hospital	as physician reimbursement flattens or falls they are expecting stipends from hospitals		
10	pre-admission process	marketing practices	outcome data utilization	incentives
11	length of stay management	ur process	peer review process	
12	financial solvency	upcoding	marketing practices	ur process
13	medical staff	admit status- i.e. top admitters vs. low admitters	marketing practices	incentives
14	stark regs			
15	specialty hospitals			
16	charity/unfunded			
17	gain sharing			
18	quality reporting			
19	stark regulations			
20	specialty hospitals			
21	charity/unfunded			
22	gain sharing			
23	quality reporting			
24	marketing/advertising	intimation of high quality care when it can't be assured 100 percent of the time		
25	material/purchasing policies	bidding/contract awarding (or lack thereof) based on service vs. price		
26	gifts to employees by vendors	definition of "gift"		
27	human resources	rewarding physicians by hiring family members and recommended friends		

28	use of administrative residents as free labor	extent of resident's responsibilities that may fall outside educational realm		
29	self referral	physicians should not be able to refer to their own facilities		
30	internal control	difficult to maintain adequate separation of duties with limited staff		
31	collecting from patients	cannot provide discounts to patients with insurance - difficult to manage with high deductibles and coinsurance		
32	policy making	ensuring that policies are properly documented, authorized, and communicated		
33	documentation	ensuring that the medical record supports the patient bill		
34	prolonging life at all cost	palliative		
35	care of undocumented alien	uncompensated care		
36	prolonged length of stay due to lack of placement	unfunded status	lack of cooperative family	
37	limited options for care after the acute phase due to lack of funding			
38	competing facilities	marketing		
39	physician self-referral	credentialing		
40	uninsured patients	bad debt vs. collection efforts		
41	govt sponsored reimbursement	balancing the budget on the back of healthcare (state and federal)		
42	non-emergent continuity of care for non funded Bexar Co. resident	fiduciary responsibility and accountability to Bexar Co. taxpayers		
43	Lack of consistent means of financial support from outlying counties for the care of their unfunded residents	legislative intervention to alleviate the inconsistencies and lack of financial support from other counties		
44	discharge planning for unfunded patient without family support or non US citizen	contributes to increase inpatient stay and to the issue of diversion of emergency patients		
45	diversion of emergency pts due to lack of beds or overload in EC	financial burden of expansion/adequate staffing concerns		
46	expediting patient discharges	diminishing length of stay		

47	financial issues	bad debt	uncompensated care	
48	coding	up/down coding	documentation by MD	
49	vendors (inappropriate marketing of physicians)	gifts to staff/medical staff		
50	pressure to provide unfunded care	referral/discharge facilities pressured to provide care for unfunded pts		
51	choice	ensuring Medicare recipients have true choice in providers and facilities during the course of an illness		
52	uncompensated care	how is high tech/high cost care paid for		
53	funding of GME	can cost/tracking/allocation be faked		
54	research funding	declining resources - how to deal with		
55	corporate influence on decisions	drug companies/med suppliers influencing practice choices		
56	ethical decision making as part of collaborative relationship	XX[a] institutions forced together by hierarchical decisions above XX[a] partners, how are conflicts resolved?		
57	pay for tenured, loyal staff vs. hire-on pay for new employees	compression adjustments	market adjustments	
58	"perks" for administrative staff	free meals	travel time off without use of vacation	PTO
59	rewards for positive behavior vs. "taxable" income			
60	giving LA evacuees Medicaid when TX residents between 18-65 years old with health problems and medical bills cannot qualify			
61	manage care contracts setting rates lower than Medicare and Medicaid rates			
62	financial solvency	uncompensated care	uncontrolled reimbursement decrease by 3rd party payers	
63	harassment	verbal	sexual	jobs threatening by physicians mostly toward nurses
64	access to services	off-loading "emergency room" into services with less access where chronic disease is involved	what is the organization's community	

65	surge capacity	overwhelming events that are under or un-planned for by the organization	incapacity to think as bad as it can get	
66	integration with public health	two isolated worlds who needs each other	defining "community" and redefining organizations role	
67	excellence v. competence	defining "excellence" and "rewards"	building workforce willing to work toward excellence, stay together, accept rewards	
68	decision theory	keeping decisions in the order of "what's best for clients", "what's best for the organization", "what's legal", and finally "what can I live with?"		
69	physician owned specialty hospitals	conflict of interest		
70	insertion of medical devices for pts comfort rather than medical necessity	fraudulent billing		
71	quality			
72	compliance			
73	HIPAA			
74	financial solvency	prioritization of uncompensated care		
75	appropriate level of care (post-acute)	organizations who accept patients who do not meet criteria for their LOC		
76	appropriate changes to reflect services provided	billing reconciliation of charges		
77	clinical staff salaries	staying with a system market or individualizing markets		
78	provision of services to the uninsured/underinsured			
79	aligning physician and organizational objectives	length of stay constraints	resource use and limitations	
80	use of patient and government resources for care	appropriate patient selection vs. financial issues		
81	equitable treatment of employees	"what's right vs. what has to be"		
82	resources to develop community support services	advocacy for disabled	educational programs on disability	availability of support services for elderly and disabled
83	stewardship	regarding use of hospital owned materials	coding/billing errors	staffing
84	diversity	management does not reflect the ethnic/racial populations served	insufficient cultural/religious sensitivity or competence	

85	communication	decisions and plans not reaching all departments	explanations or reasons for certain HR policies and application of HR policies	
86	allocation of resources	uncompensated care - how is it determined and for who		
87	financial	refusing care to patients with non-emergent conditions if no ability/willingness to pay		
88	competition from outside	marketing	doctor loyalty	
89	physician self-referral	market share	payer mix	
90	long term patient stays	financial stability vs. physician/family convenience		
91	labor unions	fight or work with		
92	financial solvency	the way patients are approached about bills	the hidden cost of emergency stays or OR (ex. CRNA, ER Doctor)	
93	financial solvency	uncompensated care		
94	harassment	includes sexual harassment, verbal abuse, intimidation, etc.		
95	financial solvency	uncompensated care		
96	financial	pts bills - they do not understand		
97	abuse	verbal, sexual		

[a]Response was illegible. Undecipherable responses were not reviewed in the expert panel process.

Appendix G – Raw Data (Round 2)

Round 2 – Clinical Responses

Q#	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	R12	R13	R14	R15	R16	R17	R18	R19	R20	R21	R22	R23	R24	R25	R26
1	5	3	5	5	5	5	4	5	4	5	5	5	5	5	5	5	5	5	5	4	5	5	5	5	5	5
2	1	2	1	3	1	2	1	4	5	1	5	1	1	4	3	3	1	4	3	4	4	3	4	3	2	3
3	5	4	4	3	5	5	4	3	3	4		4	3	4	4	5	5	3	3	3	5	5	4	5	4	4
4	4	4	3	4	3	5	1	3	3	4	4	4	3	4	3	4	5	2	3	3	5	4	4	5	4	3
5	2	4	5	5	3	5	2	2	5	4	5	3	3	5	4	4	5	5	4	3	5	5	3	5	5	3
6	5	3	5	4	5	5	3	1	5	4	5	4	4	5	5	4	5	4	4	4	5	5	4	5	4	4
7	5	3	5	4		4	4	3	5	4	5	5	4	5	3	5	5	4	5	4	5	5	5	5	5	5
8	5	3	5	3	5	5	2	3	5	4	4	5	4	5	4	5	5	4	4	4	5	5	4	5	5	5
9	3	2	4	3	3	3	1	3	4	5	5	2	1	5	4	3	5	3	4	3	3	4	5	4	4	4
10	4	5	5	4	4	4	2	3	3	5	5	5	4	5	3	4	5	5	5	4	4	5	5	4	5	5
11	5	5	5	5	5	4		5	5	5	5	5	5	5	3	5	5	5	5	4	5	5	5	4	5	4
12	4	3	5	3	4	2	1	1	5	5	5	5	3	5	3	3	4	3	4	4	3	4	4	4	5	5
13	4	3	5	3	5	4	4	4	5	5	5	5	5	5	4	4	5	5	4	4	4	5	4	5	5	5
14	4	5	5	3	3	3	1	3	3	1	5	5	5	5	3	5	4	3	4	3	5	4	5	4	4	4
15	5	3	5	3	5	5	1	2	3	5	5	5	4		4	4	5	4	5	4	4	5	5	5	4	4
16	4	3	4	3	5	3	4	5	4	4	5	4	4	4	3	5	5	3	4	3	5	5	4	5	5	4
17	4	4	4	3	3	4	1	3	5	4	5	5	4	4	3	5	5	3	5	4	5	5	4	5	5	5
18	3	1	4	2	3	1	1	1	4	1	5	2	1	3	1	2	4	3	4	2	3	4	3	2	2	2
19	1	1	1	4	1	1	1	2	5	1	5	1	1	5	4	3	1	4	4	3	4	5	5		4	5
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Note. The x-axis lists the 26 respondents; the y-axis lists the 93 clinical ethics questions.

Round 2 – Organizational Responses

Q#	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	R12	R13	R14	R15	R16	R17	R18	R19	R20	R21	R22	R23	R24	R25	R26
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72	3	2	3	1	3	5	2	1	5	1	5	4	5	2	2	4	5	4		2	4	3	3	4	5	4
73	3	2	3	2	3	3	1	1	3	1	5	3	5	2	1	2	4	4		1	3	4	2	3	5	4
74	3	1	3	1	5	1	1	2	3	1	3	4	2	1	1	2	3	1		2	4	2	2	4		2
75	3	3	4	2	3	3	4	2	5	4	3	2	5	4	2	4	4	2		3	5	2	4	3	5	3
76	3	3	4	2	3	5	5	1	3	3	3	4	5	4	3	5	5	3		3	3	5	3	4	5	4
77	3	3	1	3	2	2	2	1	5	1	4	4	1	5	2	4	3	5		2	4	5	4	4		5
78	3	3	3	3	5	2	5	3	3	1	3	4	5	4	3	4	4	5		1	4	5	4	5	5	4
79	3	3	3	4	5	1	4	1	5	3	4	5	2	1	1	5	5	4		3	4	5	3	4	5	4
80	3	3	4	4	5	5	2	2	5	3	5	5	2	5	2	5	5	4		2	4	5	5	4	5	4
81	3	3	3	3	5	2	1	2	3	4	3	5	5	1	3	3	5	5		2	5	2	4	5	5	4
82	3	1	3	3	5	5	1	2	3	3	3	5	3	5	3	4	5	3		2	3	4	4	4	5	5
83	3	1	1	1	2	2	1	1	5	2	4	5	3	4	2	4	4	5		2	3	4	3	5	5	5
84	3	1	1	2	5	1	4	1	3	1	3	2	1		1	2	3	2		2	5	2	3	2		5
85	3	1	1	1	2	1	1	1	5	1	5	5	3	5	1	4	4	3		3	3	1	4	3	5	4
86	2	1	1	2	2	5	1	1	3	3	2	2	2	5	2	3	3	4		4	3	5	4	3	5	5
87	1	2	1	1	2	3	2	1		1	2	3	1		1	3		3	3	1		5	4	4	4	5
88	3	2	1	3	2	2	5	3	2	4	3	4	2	2	4	3	5	3	2	3	4	5	5	4	5	5

89	3	2	1	5	2	4	4	1	5	3	5	3	3	5	3	4	5	3	4	4	4	5	4	4	5	5
90	3	2	3	4	2	2	3	2	3	3	3	1	2	1	2	2	5	4	2	3	3	4	3	4	4	5
91	3	2	3	3	2	3	2	1	3	2	3	2	2	4	2	3	5	5	3	3	4	5	4	4	5	4
92	3	2	4	3	5	5	4	3	3	3	3	3	3	4	2	5	5	5	3	3	4	5	4	5	4	4
93	3	2	3	4	2	3	3	1	4	2	5	2	3	3	2	3	5	4	4	1	3	5	4	4		5
94	3	2	4	3	5	5	3	2	5	2	4	3	3	5	3	3	4	4	3	4	3	5	5	4	5	5
95	3	2	1	4	2	1	4	1	5	1	5	2	1	1	1	1	4	2	3	1	3	5	2	5	5	4
96	3	2	3	3	5	5	3	3	5	3	3	5	3	5	3	4	5	5	4	4	3	5	4	5	5	
97	3	2	1	3	2	2	1	1	5	3	5	5	1	5	3	4	5	3	3	1	3	5	4	4	5	5
98	3	2	1	3	5	2	4	4	3	3	3	5	3	5	2	3	5	3	3	3	3	5	4	3	3	4
99	3	2	1	4	4	5	4	4	5	3	5	5	3	4	4	5	5	4	4	4	4	5	5	5	5	5
100	3	2	1	2	5	2	4	4	2	4	4	5	3	5	3	3	5	5	4	3	4	5	5	3	4	5
101	3	2	1	2	1	4	2	3	3	3	4	3	4	5	3	4	5	3	3	1	4	5	5	4	4	5

Note. The x-axis lists the 26 respondents; the y-axis lists the 101 organizational ethics questions.

Round 2 – Societal Responses

Q#	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	R12	R13	R14	R15	R16	R17	R18	R19	R20	R21	R22	R23	R24	R25	R26
1	4	1	3	4	3	3	4	2	4	3		5	3	3	2	4	5	2	4	3	3	5	4	5	5	5
2	2	1	3	3	1	5	5	2	3	5	5	3	3	2	2	5	4	3	3	3	3	4	3	5	5	3
3	2	1	1	3	1	1	1	1	1	1	5	5	3	1	2	2	2	5	3	1	3	4	3	4	1	4
4	2	1	1	3	1	1	1	1	5	1	5	2	1	1	1	1	2	1	3	1	2	2	3	3	2	4
5	2	1	3	3	1	4	1	3	5	5	5	5	3	5	2	3	5	3	3	1	3	5	4	4	5	5
6	2	1	1	5	1	1	3	1	5	4	5	1	3	1	1	2	5	5	3	1	3	5	4	3	1	4
7	2	1	3	3	1	5	5	2	5	4	5	5	3	5	3	4	5	3	3	4	3	5	5	3		4
8	2	1	2	3	1	1	3	2	3	1	5	1	3	1	1	2	4	1	3	1	2	5	4	4	1	4
9	2	1	1	5	1	1	1	2	5	1	5	1	4	1	1	1	3	1	3	1	2	1	2	5	1	5
10	2	1	1	2	1	1	1	1	2	1	5	1	4	1	1	1	2	1	3	1	2	1		2	1	5
11	2	1	1	4	1	1	4	1	5	1	5	1	3	1	1	1	4	1	3	1	3	3	2	4	3	5
12	2	1	1	3	1	1	1	1	5	1	5	1	4	5	1	3	1	5	3	3	3	4	3	4	3	4
13	2	1	3	3	3	5	1	1	5	3	5	3	4	2	3	4	5	1	3	3	3	5	3	4	5	4
14	2	1	1	4	3	3	1	1	5	2	5	3	2	5	3	3	4	1	3	2	2	5	4	2	5	4
15	2	1	1	5	5	2	1	1	1	3	5	5	2	1	2	2	4	1	3	1	2	1	3	1	5	4
16	2	1	1	3	1	4	4	1	5	2	5	3	2	2	2	4	3	3	3	1	3	5	3	3	5	5
17	2	1	3	4	3	2	5	1	1	2	5	3	4	5	4	4	4	5	3	4	4	5	4	3	5	5
18	2	1	1	3	1	5	1	1	3	1	5	1	1	5	2	2	3	1	3	3	2	5	3	4	5	4
19	2	1	4	3	1	5	4	1	5	5	5	2	3	5	2	4	5	5	3	3	3	5	3	4	5	5
20	2	1	4	4	1	5	1	1	5	5	5	1	5	5	3	3	5	5	4	4	4	5	4	4	5	4
21	2	1	3	2	1	2	1	1	1	1	5	1	2	1	2	5	3	4	3	1	5	2	5	4	5	5
22	2	1	4	2	1	3	4	1	2	5	5	1	3	3	3	4	3	3	3	3	3	5	4	4	5	4
23	2	1	2	2	1	1	5	1	5	4	5	1	5	3	3	4	3	3		4	3	5	3	3	1	4
24	2	1	1	3	1	1	1	1	1	1	5	1	1	1	1	2	1	1	2	1	2	1	1	3	1	2
25	2	1	1	3	1	1	1	1	1	1	5	1	5	1	1	1	1	1	2	1	2	5	2	4	1	2
26	2	1	1	2	1	1	1	1	3	1	5	1	5	1	2	4	3	1	2	3	5	5	3	4	5	3
27	2	1	3	3	5	1	1	1	1	5	5	5	3	1	2	4	5	1	2	3	2	2	3	2	5	5

Note. The x-axis lists the 26 respondents; the y-axis lists the 27 societal ethics questions.

Round 2 – Demographic Data

Q	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	R12	R13	R14	R15	R16	R17	R18	R19	R20	R21	R22	R23	R24	R25	R26
A	4	5	3	8	6	4	8	8	7	7	8	8	7	3	5	7	7	4	3	6	5	6	1	8	8	1
Y	1	1	2	5	1	1	3	1	5	6	3	1	5	1	3	1	2	1	2	4	2	5	1	5	2	1
F	1	2	1	1	1	3	2	3	1	2	3	1	3	1	2	1	1	1	1	1	3	1	1	2	3	1
G	1	1	2	1	2	2	1	1	1	1	1	2	2	1	1	1	2	1	1	1	1	1	1	1	1	1
R	1	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1	1	3	3	4	1	1	1
E	3	4	3	5	6	3	8	6	6	6	4	5	7	2	3	4	6	2	2	5	4	5	1	7	6	1

Key

A *Age*	Y *Years employed at current location*	F *Interest in San Antonio ethics forum*	G *Gender*	R *Race*	E *Years of Healthcare Experience*
1 = 20-25	1 = 0-5	1 = Yes	1 = Male	1 = White/Caucasian	1 = 0-5
2 = 26-30	2 = 6-10	2 = No	2 = Female	2 = Black	2 = 6-10
3 = 31-35	3 = 11-15	3 = Other (not sure, maybe)		3 = Hispanic	3 = 11-15
4 = 36-40	4 = 16-20			4 = Middle Eastern	4 = 16-20
5 = 41-45	5 = 21-25				5 = 21-25
6 = 46-50	6 = 26-30				6 = 26-30
7 = 51-55					7 = 31-35
8 = 56-60					8 = 36-40